STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 224 SS=E	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility neglected to feed and provide incontinence care for dependent residents for 4 of 6 sampled residents (Resident #4, #5 #6 and #7). The findings included: 1. Resident #4 was admitted to the facility on 01/21/12 with diagnoses that included hemiplegia, hemiparesis, dementia and others. A care plan updated on 05/17/16 specified the resident received a pureed diet and staff were to report to the nurse if the resident did not eat. The most recent Minimum Data Set (MDS) dated	F 224	Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor	4/22/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/21/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 1 01/19/17 specified the resident's cognition was not assessed and she required extensive to total assistance with activities of daily living including eating. The facility provided Resident #4's meal percentage intake record. Review of the meal intake record revealed there was no documentation made on 03/26/17 for Resident #4. On 03/29/17 at 12:21 PM nurse aide (NA) #3 was interviewed on the telephone and explained he worked on 03/26/17 from 3 PM to 11 PM assigned to the medical unit. NA #3 explained that on 03/26/17 on the 3 PM to 11 PM shift the facility only had 3 nurse aides on the medical unit because of a shortage and usually the medical unit had 4 nurse aides. He added that during the evening meal, NA #5 was in the dining room assisting residents which left him and NA #4 to monitor "about 30" residents, answer call lights, pass meal trays and feed dependent residents. The NA stated that he entered Resident #4's room to deliver a meal tray when he found the roommate on the floor bleeding. NA #3 stated he called for help and assisted the nurse with caring for the fallen resident because she was injured. NA #3 reported that he was unable to feed Resident #4 because he was assisting with another resident. He added that due to the time it took attending to the fallen resident, trays became very late and some of them had to be returned to the kitchen and were not offered to residents. NA #3 stated that Resident #4 was not fed the evening meal. On 03/29/17 at 12:40 PM NA #4 was interviewed on the telephone and stated she worked on	F 224	does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or any other administrative or legal proceedings. F 224 Prohibit Mistreatment/Neglect/Misappropriation of Property What measures did the facility put in place for the resident affected: On 3/29/17, the director of nursing (DON) and/or assistant director of nursing (ADON) assessed Residents #4, #5, #6, and #7. Resident assessments revealed no obvious signs of poor nutrition, change in mental status, or weight loss as a result of not receiving assistance with eating the 3/26/17 evening meal. On 3/29/17, the DON/ADON notified the physician for Residents #4, #5, #6, and #7 and the physician gave no new orders. A 24 hour and 5 day report was submitted by the administrator for Residents #4, #5, #6, and #7 to the department of health and human services (DHHS). The administrator has received a letter from DHHS. What measures were put in place for residents having the potential to be affected	

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F 224	Continued From page 2 03/26/17 from 3 PM to 11 PM. NA #4 explained that she and NA #3 were the only nurse aides on the medical unit floor to pass trays and that Nurse #1 was in the dining room helping to feed residents because of short staffing. NA #4 added that while passing trays she heard NA #3 call for help and was told a resident had fallen. The NA reported that she got further behind passing trays because NA #3 was helping the nurse attend to the injured resident. She explained that she was unable to feed Resident #4 because she ran out of time. NA #4 also stated that she told the nurse that she had not been able to feed all the residents. On 03/30/17 at 2:36 PM Nurse #1 was interviewed on the telephone and explained the night of 03/26/17 the staffing was a problem and the meals trays were late being delivered. She added that she was assisting residents in the dining room but had to leave to attend to a resident that had fallen. The nurse stated she didn't know if everyone got fed that night and didn't remember the nurse aides telling her they were unable to feed all the dependent residents. Nurse #1 stated she did not feed Resident #4. On 03/30/17 at 3:50 PM NA #5 was interviewed and reported that she worked 3 PM to 11 PM on 03/26/17. She explained that she assisted residents with eating in the dining room and fed one resident on the 400 Hall which was not Resident #4. On 03/30/17 at 6:07 PM NA #8 was interviewed on the telephone and stated she worked in the secured unit on 03/26/17 from 3 PM to 11 PM but did not assist any residents with eating on the medical unit. She stated that neither she nor NA	F 224	On 3/29/17, the social worker and admissions/social worker conducted interviews with alert and oriented residents regarding abuse/neglect with no negative findings. On 4/19/17, the social worker reviewed the past 60 days of Resident Concerns to identify any potential abuse/neglect concerns. No unaddressed abuse/neglect concerns were identified. On 4/6/17, the activity director called for a resident council meeting to ensure resident council members had an opportunity to express any abuse/neglect concerns. What systems were put in place to prevent the deficient practice from reoccurring: On 4/3/17, the DON initiated an in-service for all staff on abuse/neglect. After 4/22/17, staff will not be allowed to complete their shift until this abuse/neglect in-service is completed. This in-service will be incorporated into new employee orientation. On 4/4/17, the DON verified the posting of the DON, ADON, and administrator phone numbers at the nurse stations so staff may contact the DON, ADON, and/or administrator when the need arises to prevent and/or report abuse/neglect. How the facility will monitor systems put in	

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F 224	Continued From page 3 #7 left the secured unit on 03/26/17 to assist feeding residents on the medical unit. Attempts were made to contact NA #7 for an interview but she was unable to be reached. On 03/30/17 at 4:15 PM the Director of Nursing (DON) was interviewed ad explained she was aware of staffing shortage on 03/26/17 and even came in to answer call lights and pass ice on the 7 AM to 3 PM shift but left at the end of the shift. She stated she wasn't aware that 3 PM to 11 PM shift had been short staffed and would have expected the nurse to contact her if there had been problems. The DON added that she returned to work on 03/27/17 but was unable to attend the morning administration meeting because she had to work a medication cart. The DON was unaware that Resident #4 did not get fed on 03/26/17. On 03/30/17 at 4:45 PM the Administrator was interviewed and explained that the facility had procedures for calling additional resources into the facility to assist with resident care and that it would never be okay to not feed a resident because of short staffing. The Administrator stated she was unaware that on 03/26/17 on the 3 PM to 11 PM shift did not have enough staff to ensure all residents were fed the evening meal. 2. Resident #5 was admitted to the facility on 12/16/16 with diagnoses that included femur fracture, anxiety and others. The most recent Minimum Data Set (MDS) dated 02/23/17 specified the resident's cognition was not assessed and she required extensive assistance with activities of daily living and required setup and assistance with eating.	F 224	place: On 3/29/17, the DON, ADON, staff nurse, weekend supervisor, weekend manager on duty, and/or corporate consultant began auditing dining rooms and resident rooms during meal times to ensure residents are receiving assistance with eating meals. The audits are recorded on the Showers/CHOICES/ADLs audit tool. If the auditor identifies a resident is not receiving assistance with eating a meal, the auditor will take prompt corrective action and document the intervention on the audit tool. The Showers/CHOICES/ADLs audit tool will be completed for five (5) residents daily five (5) times per week for four (4) weeks, then five (5) residents weekly for four (4) weeks, then five (5) residents monthly for two (2) months. Completed the Showers/CHOICES/ADLs audit tool will be forwarded to and reviewed by the DON and/or ADON. The DON or ADON will present the findings of the Showers/CHOICES/ADLs audit tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as needed or appropriate for continued compliance. Also, the DON and/or ADON will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed	

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F 224	Continued From page 4 A care plan (date not provided) specified staff were to provide tray set up, encourage and provide assistance with eating. The facility provided Resident #5's meal percentage intake record. Review of the meal intake record revealed there was no documentation made on 03/26/17 for Resident #5. On 03/29/17 at 12:21 PM nurse aide (NA) #3 was interviewed on the telephone and explained he worked on 03/26/17 from 3 PM to 11 PM assigned to the medical unit. NA #3 explained that on 03/26/17 on the 3 PM to 11 PM shift the facility only had 3 nurse aides on the medical unit because of a shortage and usually the medical unit had 4 nurse aides. He added that during the evening meal, NA #5 was in the dining room assisting residents which left him and NA #4 to monitor "about 30" residents, answer call lights, pass meal trays and feed dependent residents. The NA stated that while delivering trays, he entered a resident's room and found a resident in the floor bleeding. NA #3 stated he called for help and assisted the nurse with caring for the fallen resident because she was injured. NA #3 reported that he was unable to feed Resident #5 because he was assisting with another resident. He added that due to the time it took attending to the fallen resident, trays became very late and some of them had to be returned to the kitchen and were not offered to residents. NA #3 stated that Resident #5 was not given the evening meal. On 03/29/17 at 12:40 PM NA #4 was interviewed on the telephone and stated she worked on 03/26/17 from 3 PM to 11 PM. NA #4 explained	F 224	or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 5	F 224		

that she and NA #3 were the only nurse aides on the medical unit floor to pass trays and that Nurse #1 was in the dining room helping to feed residents because of short staffing. NA #4 added that while passing trays she heard NA #3 call for help and was told a resident had fallen. The NA reported that she got further behind passing trays because NA #3 was helping the nurse attend to the injured resident. She explained that she was unable to serve Resident #5 her tray because she ran out of time. The NA added that Resident #5 usually ate in the dining room, but hadn't that night. NA #4 also stated that she told the nurse that she had not been able to feed all the residents.

On 03/30/17 at 2:36 PM Nurse #1 was interviewed on the telephone and explained the night of 03/26/17 the staffing was a problem and the meals trays were late being delivered. She added that she was assisting residents in the dining room but had to leave to attend to a resident that had fallen. The nurse stated she didn't know if everyone got fed that night and didn't remember the nurse aides telling her they were unable to feed all the dependent residents. Nurse #1 stated she did not feed Resident #5.

On 03/30/17 at 3:50 PM NA #5 was interviewed and reported that she worked 3 PM to 11 PM on 03/26/17. She explained that she assisted residents with eating in the dining room and fed one resident on the 400 Hall which was not Resident #5.

On 03/30/17 at 6:07 PM NA #8 was interviewed on the telephone and stated she worked in the secured unit on 03/26/17 from 3 PM to 11 PM but did not assist any residents with eating on the

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F 224	Continued From page 6	F 224		

medical unit. She stated that neither she nor NA #7 left the secured unit on 03/26/17 to assist feeding residents on the medical unit. Attempts were made to contact NA #7 for an interview but she was unable to be reached.

On 03/30/17 at 4:15 PM the Director of Nursing (DON) was interviewed ad explained she was aware of staffing shortage on 03/26/17 and even came in to answer call lights and pass ice on the 7 AM to 3 PM shift but left at the end of the shift. She stated she wasn't aware that 3 PM to 11 PM shift had been short staffed and would have expected the nurse to contact her if there had been problems. The DON added that she returned to work on 03/27/17 but was unable to attend the morning administration meeting because she had to work a medication cart. The DON was unaware that Resident #5 did not get served a meal tray on 03/26/17.

On 03/30/17 at 4:45 PM the Administrator was interviewed and explained that the facility had procedures for calling additional resources into the facility to assist with resident care and that it would never be okay to not feed a resident because of short staffing. The Administrator stated she was unaware that on 03/26/17 on the 3 PM to 11 PM shift did not have enough staff to ensure all residents were fed the evening meal.

3. Resident #6 was admitted to the facility on 03/12/17 with diagnoses that included dementia, adult failure to thrive and others. The admission Minimum Data Set (MDS) dated 03/19/17 had validation errors and no other MDS was available.

Review of the medical record for Resident #6 revealed she was ordered to perceive a pureed

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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F 224	Continued From page 7	F 224		

diet and was receiving Palliative Care services. The medical record also indicated the resident was dependent on staff for eating.

The facility provided Resident #6's meal percentage intake record. Review of the meal intake record revealed there was no documentation made on 03/26/17 for Resident #6.

On 03/29/17 at 12:21 PM nurse aide (NA) #3 was interviewed on the telephone and explained he worked on 03/26/17 from 3 PM to 11 PM assigned to the medical unit. NA #3 explained that on 03/26/17 on the 3 PM to 11 PM shift the facility only had 3 nurse aides on the medical unit because of a shortage and usually the medical unit had 4 nurse aides. He added that during the evening meal, NA #5 was in the dining room assisting residents which left him and NA #4 to monitor "about 30" residents, answer call lights, pass meal trays and feed dependent residents. The NA stated that while delivering trays, he entered a resident's room and found a resident in the floor bleeding. NA #3 stated he called for help and assisted the nurse with caring for the fallen resident because she was injured. NA #3 reported that he was unable to feed Resident #6 because he was assisting with another resident. He added that due to the time it took attending to the fallen resident, trays became very late and some of them had to be returned to the kitchen and were not offered to residents. NA #3 stated that Resident #6 was fed the evening meal.

On 03/29/17 at 12:40 PM NA #4 was interviewed on the telephone and stated she worked on 03/26/17 from 3 PM to 11 PM. NA #4 explained that she and NA #3 were the only nurse aides on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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F 224	Continued From page 8	F 224		

the medical unit floor to pass trays and that Nurse #1 was in the dining room helping to feed residents because of short staffing. NA #4 added that while passing trays she heard NA #3 call for help and was told a resident had fallen. The NA reported that she got further behind passing trays because NA #3 was helping the nurse attend to the injured resident. She explained that she was unable to feed Resident #6 her tray because she ran out of time. The NA added that Resident #6 took an extremely long time to eat and she did not have time to feed the resident and attend to the other residents. NA #4 also stated that she told the nurse that she had not been able to feed all the residents.

On 03/30/17 at 2:36 PM Nurse #1 was interviewed on the telephone and explained the night of 03/26/17 the staffing was a problem and the meals trays were late being delivered. She added that she was assisting residents in the dining room but had to leave to attend to a resident that had fallen. The nurse stated she didn't know if everyone got fed that night and didn't remember the nurse aides telling her they were unable to feed all the dependent residents. Nurse #1 stated she did not feed Resident #6.

On 03/30/17 at 3:50 PM NA #5 was interviewed and reported that she worked 3 PM to 11 PM on 03/26/17. She explained that she assisted residents with eating in the dining room and fed one resident on the 400 Hall which was not Resident #6.

On 03/30/17 at 6:07 PM NA #8 was interviewed on the telephone and stated she worked in the secured unit on 03/26/17 from 3 PM to 11 PM but did not assist any residents with eating on the

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F 224	Continued From page 9	F 224		

medical unit. She stated that neither she nor NA #7 left the secured unit on 03/26/17 to assist feeding residents on the medical unit. Attempts were made to contact NA #7 for an interview but she was unable to be reached.

On 03/30/17 at 4:15 PM the Director of Nursing (DON) was interviewed and explained she was aware of staffing shortage on 03/26/17 and even came in to answer call lights and pass ice on the 7 AM to 3 PM shift but left at the end of the shift. She stated she wasn't aware that 3 PM to 11 PM shift had been short staffed and would have expected the nurse to contact her if there had been problems. The DON added that she returned to work on 03/27/17 but was unable to attend the morning administration meeting because she had to work a medication cart. The DON was unaware that Resident #6 was not fed the evening meal on 03/26/17.

On 03/30/17 at 4:45 PM the Administrator was interviewed and explained that the facility had procedures for calling additional resources into the facility to assist with resident care and that it would never be okay to not feed a resident because of short staffing. The Administrator stated she was unaware that on 03/26/17 on the 3 PM to 11 PM shift did not have enough staff to ensure all residents were fed the evening meal.

4. Resident #7 was admitted to the facility on 02/05/16. His diagnoses included dementia with behaviors, diabetes, congestive heart failure, and having repeated falls.

The significant change Minimum Data Set (MDS) dated 11/02/16 coded his cognition with long and short term memory impairments and severely

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 10	F 224		

impaired decision making abilities. He was coded as requiring total assistance of one staff for eating and extensive assistance of 2 staff for toileting. He was also coded as being nonambulatory and always incontinent.

The quarterly MDS, dated 02/02/17, coded his cognition as not being assessed, requiring extensive to total assistance with ADLs, being nonambulatory, and always being incontinent.

On 03/29/17 at 11:46 AM an interview was conducted with Resident #7's responsible party (RP) who stated he came several times a week to feed Resident #7. He stated that he felt the staff were working short and gave the example of finding Resident #7 lying in a soaked bed which included the top sheet on 03/18/17 at 11:40 AM. He stated that he found a clean sheet in the room to replace the soiled one. He stated he told staff at this time about Resident #7 needing to be changed and the nurse aide stated she would return after she passed trays and fed other residents. RP stated Resident #7's tray arrived at 12:15 PM, the RP fed Resident #7 his lunch meal. The RP stated the nurse aide did not return to change Resident #7 until 2:00 PM.

Review of the staffing records revealed the nurse aide (NA) responsible for Resident #7 on 03/18/17 during first shift was NA #2.

NA #2 was interviewed on 03/29/17 at 2:42 PM. NA #2 stated that she was the aide who was told Resident #7 needed to be changed on 03/18/17 by the RP. NA #2 stated it was around 11:40 AM when the RP told her Resident #7 was wet. NA #2 stated she told him she would return but had to pass out the trays and feed other residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 224	Continued From page 11 first. She stated that she had to be sure residents received hot food and since Resident #7 required 2 staff to provide care she decided to wait to change him until after the meal as other nurse aides were busy with the meal. NA #2 stated she finished passing out the trays and fed 3 other residents. She then collected the trays and returned to change Resident #7 but did not think it was as late as 2:00 PM. NA #2 stated the delay in care was not related to staffing but the need to pass trays and feed residents so their food was hot. During interview on 03/30/17 at 12:00 PM, the Director of Nursing stated she expected staff to provide the necessary care to the resident and seek assistance for help if needed. She stated telling a family to wait until the trays were passed was not acceptable. She further stated she did not think this was neglect as the aide intended to provide the incontinent care when she was finished with the other residents. Interview with the Administrator on 03/30/17 at 4:39 PM revealed her expectation was for staff to check for incontinence prior to meal delivery. If a resident was noted to need care during a meal, she expected staff to seek assistance with passing trays so care could be provided timely.	F 224		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 241		4/22/17

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F 241	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and family interview, the facility failed to maintain the dignity of 1 of 2 residents sampled for dignity when staff failed to change Resident #7 timely when family informed staff he was soiled and needed assistance resulting in him being fed by family soiled. The findings included: Resident #7 was admitted to the facility on 02/05/16. His diagnoses included dementia with behaviors, diabetes, congestive heart failure, and having repeated falls. The significant change Minimum Data Set (MDS) dated 11/02/16 coded his cognition with long and short term memory impairments and severely impaired decision making abilities. He was coded as requiring total assistance of one staff for eating, and extensive assistance of 2 staff for toileting. He was also coded as being nonambulatory and always incontinent. The quarterly MDS, dated 02/02/17, coded his cognition as not being assessed, requiring extensive to total assistance with ADLs, being nonambulatory, and always being incontinent. On 03/29/17 at 11:46 AM an interview was conducted with Resident #7's responsible party (RP) who stated he came several times a week to feed Resident #7. He stated that he felt the staff were working short and gave the example of finding Resident #7 lying in a soaked bed which included the top sheet on 03/18/17 at 11:40 AM. He stated that he found a clean sheet in the room	F 241	F 241 Dignity and Respect of Individuality What measures did the facility put in place for the resident affected: On 3/18/17, at 2:00 PM the nursing assistant (NA) returned to assist Resident #7 with incontinence care. On 3/29/17, the director of nursing (DON) assessed Resident #7. Resident #7□s skin clean and intact and the brief was dry. What measures were put in place for residents having the potential to be affected On 3/29/17, the director of social services and the social worker conducted interviews with alert and oriented residents regarding dignity and respect of individuality, including incontinence care before meals. The interviews resulted with no negative findings. On 4/6/17, the activity called for a resident council meeting to ensure resident council members had an opportunity to express any dignity and respect of individuality concerns. On 4/19/17, the social worker reviewed the past 60 days of Resident Concerns to identify any potential dignity and respect of individuality concerns. No unaddressed dignity and respect of individuality	

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F 241	Continued From page 13 to replace the soiled one. He stated he told staff at this time about Resident #7 needing to be changed and the nurse aide stated she would return after she passed trays and fed other residents. RP stated Resident #7's tray arrived at 12:15 PM, the RP fed Resident #7 his lunch meal. The RP stated the nurse aide did not return to change Resident #7 until 2:00 PM. Review of the staffing records revealed the nurse aide (NA) responsible for Resident #7 on 03/18/17 during first shift was NA #2. NA #2 was interviewed on 03/29/17 at 2:42 PM. NA #2 stated that she was the aide who was told Resident #7 needed to be changed on 03/18/17 by the RP. NA #2 stated it was around 11:40 AM when the RP told her Resident #7 was wet. NA #2 stated she told him she would return but had to pass out the trays and feed other residents first. She stated that she had to be sure residents received hot food and since Resident #7 required 2 staff to provide care she decided to wait to change him until after the meal as other nurse aides were busy with the meal. NA #2 stated she finished passing out the trays and fed 3 other residents. She then collected the trays and returned to change Resident #7 but did not think it was as late as 2:00 PM. NA #2 stated the delay in care was not related to staffing but the need to pass trays and feed residents so their food was hot. During interview on 03/30/17 at 12:00 PM, the Director of Nursing stated she expected staff to provide the necessary care to the resident and seek assistance for help if needed. She stated telling a family to wait until the trays were passed was not acceptable.	F 241	concerns were identified. What systems were put in place to prevent the deficient practice from reoccurring: On 3/31/17, the DON initiated an in-service for all nursing staff on Dignity and Respect of Individuality. As of 4/22/17, nursing staff will not be allowed to complete their shift until this Dignity and Respect of Individuality in-service is completed. This in-service will be incorporated into new employee orientation. On 4/4/17, the DON verified the posting of the DON, ADON, and administrator phone numbers at the nurse stations so staff may contact the DON, ADON, and/or administrator when the need arises to protect a resident□s dignity and respect of individuality. How the facility will monitor systems put in place: On 4/22/17, the DON, ADON, staff nurse, weekend supervisor, the weekend manager on duty, and/or corporate consultant began auditing dining rooms and resident rooms during meal times to ensure residents are receiving incontinence care and not having to eat a meal when incontinence care is needed. The audits are recorded on the Showers/CHOICES/ADLs audit tool. If the auditor identifies a resident is not receiving assistance with needed	

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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F 241	Continued From page 14 Interview with the Administrator on 03/30/17 at 4:39 PM revealed her expectation was for staff to check for incontinence prior to meal delivery. If a resident was noted to need care during a meal, she expected staff to seek assistance with passing trays so care could be provided timely.	F 241	incontinence care prior to eating a meal, the auditor will take prompt corrective action and document the intervention on the audit tool. The Showers/CHOICES/ADLs audit tool will be completed for five (5) residents daily five (5) times per week for four (4) weeks, then five (5) residents weekly for four (4) weeks, then five (5) residents monthly for two (2) months. Completed Showers/CHOICES/ADLs audit tool tools will be forwarded to and reviewed by the DON and/or ADON. The DON or ADON will present the findings of the Showers/CHOICES/ADLs audit tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as needed or appropriate for continued compliance in this area. Also, the DON and/or ADON will present findings for four (4) months at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 281		4/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 15 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to follow the physician's order for 1 of 3 sampled residents (Resident #8) reviewed for unnecessary medications. An order for Fentanyl patch 25 micrograms (mcg) per hour 1 patch to skin every 72 hours was not administered correctly for Resident #8. Findings included: Resident #8 was admitted to the facility on 08/11/16 with diagnoses which included cancer, cerebral infarction, hemiplegia affecting the right side, and urinary tract infection (UTI). He was discharged from the facility on 03/27/17 to another facility. Review of Resident #8's quarterly Minimum Data Set (MDS) dated 12/09/16 revealed an assessment of intact cognition. Review of Resident #8's care plan dated 12/20/16 revealed he was care planned for Hospice care and services. The care plan stated that he was under Hospice care due to disease processes of cancer, dementia and malnutrition. The goal was for the resident to not experience pain without appropriate nursing intervention. The interventions included diet as ordered, encourage and assist with good oral hygiene, encourage fluids as tolerated, encourage resident to participate in activities of daily living (ADL) as	F 281	F 281 Professional Standards What measures did the facility put in place for the resident affected: On 3/23/17, the nurse removed the older of two Fentanyl patches, leaving one Fentanyl patch 25 micrograms (mcg) as ordered by the physician. On 3/23/17, the medication error of having two Fentanyl 25 mcg patches on at the same time was reported to the prescribing practitioner. The prescribing practitioner gave no new orders. What measures were put in place for residents having the potential to be affected On 3/29/17, the director of nursing (DON), assistant director of nursing (ADON), and corporate facility consultants reviewed all residents with narcotic medication patches, including Fentanyl patches, to ensure that orders had been carried out properly and residents had the correct number of narcotic medication patches on their person. There were no negative findings. What systems were put in place to prevent the deficient practice from reoccurring:	

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F 281	Continued From page 16	F 281		

tolerance level allows, notify physician of significant changes, provide supportive, private environment for resident and family and turn and reposition frequently.

A review of Resident #8's physician orders revealed an order on 03/03/17 to change the resident's Fentanyl patch from 12.5 to 25 micrograms (mcg) every 72 hours. There were also orders for the following medications: Morphine sulfate (MS) 20 milligrams (mg) per milliliter (ml) - give 5 mg every 2 hours as needed for pain or shortness of breath - give 0.25 ml to equal 5 mg and Lorazepam 0.5 mg - give 1 tablet every 4 hours as needed for nausea or restlessness and Lorazepam 0.5 mg every 4 hours as needed for anxiety/anxiousness. On 03/16/17 an order was written to please cover Fentanyl patch with tegaderm to keep patch from falling off.

A review of Resident #8's progress notes revealed a health status note written 03/20/17 at 12:43 AM by Nurse #5 and it read "no Fentanyl patch found on resident. New patch applied to upper back between shoulders. Resident comfortably in bed."

A review of Resident #8's Medication Administration Record (MAR) for March, 2017 revealed that he had received Fentanyl 25 micrograms (mcg) per hour - 1 patch to skin every 72 hours on 03/04, 03/07, 03/10, 03/13, 03/19, 03/22 and 03/25. A review of the narcotic sign out sheet revealed the Fentanyl patches came in boxes of 5 and Resident #8 had patches signed out on 03/07, 03/10, 03/13, 03/16, 03/20 (completing one box), 03/20, 03/22, and 03/25 (from a second box). There was no patch signed

On 3/29/17, the DON initiated an in-service for RNs, LPNs, and medication aides regarding medication patches: 1) patches must be changed as ordered, 2) old patches must be removed when applying a new patch or as ordered.

How the facility will monitor systems put in place:

Beginning 4/22/17, the DON, ADON, treatment nurse, nurse supervisor/charge nurse, and/or corporate consultant will conduct an audit of eight (8) medication patches applied to residents, to verify the facility is following the physician□s order for the medication patch to ensure patches are administered correctly (if there are less than eight patches prescribed, then all patches will be audited). The audit will be completed weekly x 8 weeks. After 8 weeks, audits will continue of four (4) patches weekly x 8 weeks.

The DON or ADON will present the findings of the Medication Patch Audit tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as needed or appropriate for continued compliance.

Also, the DON and/or ADON will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 17 out on 03/19 as indicated that it was given on the MAR; however, there were 2 patches signed out of 2 different boxes and applied to 2 different areas of the body, one to the back and one to the arm. An interview with Resident #8's family member on 03/29/17 at 10:06 AM revealed she had moved the resident to another facility on Monday, March 27, 2017. The family member stated she was concerned Resident #8 was being over medicated. She stated on 03/23/17 when she visited him she discovered that he had 2 Fentanyl patches on his body. The family member stated the patches were dated with 2 different dates but she could not recall what the dates were. She stated one patch was on his back and not visible from the front and one patch was on his chest. The family member stated Resident #8 was groggy but aroused. She stated she brought the 2 patches to the attention of Nurse #1 and Nurse #2 also saw the patches. She stated Nurse #1 removed the oldest patch and left the newest one on Resident #8. The family member stated the nurse assessed the resident and he was within his normal limits and there was no adverse effect except that the resident was sleepy. An interview with Nurse #3 on 03/29/17 at 2:46 PM revealed she recalled seeing Resident #8 had 2 Fentanyl patches on sometime last week (could not remember exact date). She stated she had gone into the room with Nurse #1 because she was witnessing Nurse #1 give the resident morphine sulfate and 2 nurses have to be present during the administration of the medication. Nurse #3 stated she and Nurse #1 came out of the room and the family member came out shortly thereafter and told Nurse #1 that Resident #8 had	F 281	or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	

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F 281	Continued From page 18	F 281		

2 Fentanyl patches on him. Nurse #1 went into the room and assessed the resident and Nurse #3 followed her to check his vitals and Nurse #1 removed the older patch and left the patch from 03/22/17 on the resident. Nurse #3 stated the resident was no more drowsy than usual and there were no negative outcomes to the resident from the 2 patches.

A phone interview with Nurse #1 on 03/29/17 at 3:12 PM revealed she remembered Resident #8 having 2 Fentanyl patches on during the previous week. She stated that it was around shift change and the resident's family member brought to her attention that the resident had 2 Fentanyl patches on his body. Nurse #1 stated she went into the room and found 2 patches on the resident - one was on his back and another was on his chest. She stated they were both dated - one being older than the other but could not recall the exact dates. Nurse #1 further stated apparently on 03/20/17 a patch came off the resident and a one-time order was obtained from the Nurse Practitioner to apply another patch. She stated that the one -time order was not recorded in the physician's orders or the nurse's notes.

A phone interview with Nurse #4 on 03/29/17 at 3:24 PM revealed that he remembered Resident #8. He stated on 03/20/17 he was working with 2 medication aides (MAs) and Resident #8's patch was not on him so he called the nurse practitioner (NP) and received a one-time order to place a Fentanyl patch on the resident. Nurse #4 stated that he signed out the patch and Medication Aide (MA) #2 applied the patch to the resident's arm. Nurse #4 stated that the resident was not having any visible signs of pain when MA #2 applied the patch. Nurse #4 stated the Administrator had met

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F 281	Continued From page 19 with the resident's family member and she was upset because his patch had come off in the bed, so Nurse #4 said he made sure the patch had tegaderm over it to keep it in place. He stated that he was not aware the resident had been found with 2 patches on him until after it had happened and did not recall seeing another patch on the resident when MA #2 applied the patch on 03/20/17. A phone interview with Nurse #2 on 03/30/17 at 2:03 PM revealed that she did not recall a time that Resident #8 had 2 patches and did not remember ever taking care of him. She stated that she worked on the other medication cart most of the time. A phone interview with Medication Aide #2 attempted on 03/30/17 at 2:13 PM with no return call. A phone interview with Nurse #5 attempted on 03/30/17 at 2:15 PM with no return call. An interview with the Director of Nursing (DON) on 03/30/17 at 4:12 PM revealed her expectation was for the nurses and medication aides to administer medications as ordered by the physician and with patches to remove the old patch and destroy it prior to the application of a new patch.	F 281		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		4/22/17

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F 312	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to provide incontinence care, showers, bed baths and oral care as needed for 1 of 6 residents (Resident #9) reviewed for activities of daily living (ADL). Findings included: Resident #9 was admitted to the facility on 06/03/14 and readmitted on 01/23/17. Her diagnoses included multiple sclerosis (MS), contractures and hypotension. Review of her quarterly Minimum Data Set (MDS) dated 01/30/17 revealed an assessment of intact cognition. The MDS revealed Resident #9 was extensive to total assist of 1 to 2 persons with all aspects of activities of daily living (ADL), and totally dependent with 2 persons for bathing and personal hygiene. The MDS also revealed Resident #9 frequently had pain at a level of 10 and had a stage 4 pressure ulcer on her sacrum. A review of Resident #9's care plan dated 01/31/17 revealed that she was care planned for urinary incontinence related to her loss of muscle tone and physical immobility. The goal was for the resident to be free of urinary tract infection (UTI) through the next review period 04/31/17. The interventions included encourage adequate fluid intake, monitor for signs and symptoms of UTI such as frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea, vomiting, flank pain and hematuria and notify physician, obtain labs as ordered and notify physician of abnormal findings, perineal care after each incontinent episode, and protection and	F 312	F 312 ADL Care Dependent Residents What measures did the facility put in place for the resident affected: On 3/30/17, two nursing assistants assisted Resident #9 with personal care and repositioning. What measures were put in place for residents having the potential to be affected On 4/2/17, the director of nursing (DON), assistant director of nursing (ADON), hall nurses, and medication aides audited 100% of residents to ensure residents had received assistance with personal care. Any areas of concern were immediately addressed by the auditors. What systems were put in place to prevent the deficient practice from reoccurring: On 3/31/17, the DON and ADON initiated an in-service for 100% of registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants (NAs). The in-service instructed staff to provide to a resident who is unable to carry out activities of daily living the necessary services and to maintain good nutrition, grooming, and personal and oral hygiene. After 4/22/17, no RN, LPN, or NA will be allowed to work until the in-service is completed. All newly hired RNs, LPNs,	

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F 312	Continued From page 21 containment program. An observation of Resident #9 on 03/29/17 at 12:25 PM revealed her being assisted with her lunch. The head of her bed was slightly elevated and she was conversing with the nurse aide (NA) #6 who was feeding her lunch. An observation of Resident #9 on 03/29/17 at 3:30 PM revealed her resting in bed and talking with a visitor. An interview with nurse aide (NA) #8 on 03/30/17 at 5:45 AM revealed that he did his best to get everything done for his patients but made it hard when 2 people were needed to get residents up or do care on third shift. The NA stated that he did not always get everything done on his shift because there were not enough NAs working on third shift. NA #8 stated when residents required 2 persons he would have to find someone who was already busy with their residents and wait for them to get free to assist him. He stated that it just makes care difficult with so few staff on night shift. An observation of Resident #9 on 03/30/17 at 10:40 AM revealed that she was lying in bed with bed clothing on and covers pulled up over her. The curtain was pulled around her roommate's bed and NA #6 was in the room providing incontinence care for her. NA #6 told Resident #9 she would be back to change her when she found someone to assist her. An interview with Resident #9 on 03/30/17 at 10:45 AM revealed that she had been at the facility for about 3 years and that care had been "okay off and on for the last 3 years." She stated	F 312	and NAs will receive the in-service during new employee orientation. How the facility will monitor systems put in place: On 4/22/17, the DON, ADON, hall nurses, staff nurses, medication aides, treatment nurse, MDS nurses, social workers, activities director, staff facilitator, and/or corporate consultants began auditing to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The audits are documented on the Showers/CHOICES/ADLs audit tool. The Showers/CHOICES/ ADLs audit tool will be completed for five (5) residents daily five (5) times per week for four (4) weeks, then five (5) residents weekly for four (4) weeks, then five (5) residents monthly for two (2) months. The DON or ADON will present the findings of the Showers/CHOICES/ADLs audit tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as needed or appropriate for continued compliance in this area. Also, the DON and/or ADON will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and	

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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F 312	Continued From page 22 that she did not get showers like she should (2 times per week) and had not really had complete bed baths as often as she would like (every other day). She stated the nurse aides (NAs) did the best they could do. Resident #9 stated it was difficult to get her in the shower because it took 2 people and the NAs were really busy. She stated there used to be a shower team but because of budget reasons (according to the staff) there was no longer a team. Resident #9 stated that she did not receive oral care 2 times a day, and she had to ask for it to be done, and it was not even done once a day. She stated that she was wet and had not been changed since 10:00 PM last night. She stated NA #6 would be back to change her when she found a helper. Incontinence care provided by NA #6 and NA #7 for Resident #9 was observed on 03/30/17 at 11:24 AM. The resident had a wet brief and there was a large amount of loose brown stool leaking out of the resident's brief onto the pad on the bed. There was a brown spot on the bottom sheet as well. The resident had some brown material dried onto her hip area that NA #6 had to rub several times to remove from her skin. NA #6 cleaned the resident wiping front to back and thoroughly cleaned the hip area. NA #6 applied barrier cream to the reddened areas of Resident #9's perineum, a clean brief was applied and the resident was positioned with pillows for comfort. A request for documentation of showers and bed baths for Resident #9 was made to NA #6 on 03/30/17 at 12:00 PM and the NA stated that she had not been documenting care because there was not enough time to document and take care of the residents. NA #6 stated the documentation would not be an accurate record.	F 312	to determine the need for and/or frequency of the continued QI monitoring.	

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F 312	Continued From page 23	F 312		

An interview on 03/30/17 at 11:57 AM with NA #6 and NA #7 revealed that Resident #9 was assigned to NA #6. NA #6 stated that she had not been able to change the resident before then because she had to wait for someone to assist her. NA #6 stated that she had told Resident #9 that she would be back to change her as soon as she could find someone to help her. Both NA #6 and NA #7 stated they rounded and changed the residents that only required 1 person and then worked together to change the residents that required the assistance of 2 staff members. They both stated they had 14 to 16 residents assigned to them and it was difficult to get showers/baths, incontinence care and oral care done with that many residents. NA #6 and NA #7 stated it was especially hard to care for the residents like Resident #9 that required 2 persons for all activities of daily living except eating and oral care. NA #6 stated that she had not offered oral care to Resident #9 yet because she still had to shower and change other residents and did not remember the last time she offered oral care to the resident.

A phone interview with NA #8 on 03/30/17 at 1:55 PM revealed that he was assigned to Resident #9 the previous evening on 03/29/17. He stated that Resident #9 preferred females to change her so he did not change her during the night last night but stated that the NAs he worked with had changed her. He stated that he had not asked them to change her but they knew she had to be changed and would not allow a male NA to change her.

A phone interview with NA #9 on 03/30/17 at 2:11 PM revealed that she had worked the previous

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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F 312	Continued From page 24 evening on 03/29/17 on the halls with NA #8 and NA #10. NA #9 stated that she did not provide incontinence care for Resident #9 that evening. She stated that NA #8 had not asked her and NA #10 to change the resident. An interview on 03/30/17 at 4:10 PM with the Administrator and Director of Nursing revealed they were aware the NAs had not been documenting their care for some weeks and agreed that it would not be an accurate record of resident care. An interview on 03/30/2017 at 4:12 PM with the Director of Nursing revealed that her expectation was for residents to receive incontinence care at least every 2 to 3 hours and as needed. She stated that she also expected residents to be bathed according to their preference and that oral care be provided to residents at least 2 times per day.	F 312		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited	F 323		4/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 25 to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide adequate supervision for a resident with a history of falls. The resident fell out of bed and was injured. The resident was sent to the Emergency Department diagnosed with right eye contusion and subconjuctival hemorrhage. The facility also failed to ensure fall precautions were in place for 2 of 4 sampled residents (Resident #2 and #7). The findings included: 1. Resident #2 was admitted to the facility on 03/30/15 and readmitted on 02/13/16 with diagnoses that included aphasia, dementia, history of falls and others. The most recent Minimum Data Set (MDS) dated 02/09/17 specified the resident's cognition was not assessed, the resident required extensive assistance with bed mobility and transfers and had 1 fall with a minor injury. A care plan (not dated with the most recent update) created for Resident #2's risk for falls identified measure in place to prevent a fall related injury. The measures included:	F 323	F 323 Accident Hazards/Supervision/Devices What measures did the facility put in place for the resident affected: On 3/24/17, the assigned staff nurse assessed Resident #2 post-fall, contacted the physician, and received physician orders to send Resident #2 to the emergency department for further evaluation. Resident #2 was transferred to the hospital emergency department. The assigned staff nurse also contacted Resident #2□s responsible party. On 3/26/17, the assigned staff nurse assessed Resident #2 post-fall, contacted the physician, and received physician orders to send Resident #2 to the emergency department for further evaluation. Resident #2 was transferred to the hospital emergency department. The assigned staff nurse also contacted Resident #2□s responsible party.	

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F 323	Continued From page 26 - Bed in lowest position - Fall mat on floor - Sensor alarm while in bed and in chair A nurses' entry made by Nurse #2 on 03/24/17 at 4:00 AM specified Resident #2 was found in the floor next to her low bed with a 1 inch laceration to the cheek. Nurse #2 documented that she contacted the physician and received orders to send Resident #2 to the Emergency Department for evaluation of fall. Review of the Emergency Department evaluation dated 03/24/17 specified Resident #2 had a closed head injury without loss of consciousness (concussion) and received treatment to the facial laceration. A physician's order dated 03/26/17 specified to send Resident #2 to the Emergency Department for evaluation of a fall. There was no nurses' entry made in the medical record related to a fall on 03/26/17. The facility provided an incident report completed by Nurse #1 dated 03/26/17 at 7:18 PM that specified a nurse aide found the resident lying on her right side next to her bed. Nurse #1 assessed Resident #2 and noted the resident to have reopened the right cheek laceration and sustained an injury to the right eye. Nurse #1 documented that she contacted the on-call physician and received orders to send the resident to the Emergency Department for evaluation. The hospital records were obtained for Resident #2 and reviewed. Resident #2 remained in	F 323	On 3/28/17, the assistant director of nursing assessed Resident #7 post-fall. Resident #7 was assessed as having no injury. The assistant director of nursing notified Resident #7's responsible party and physician. Resident #7□s physician gave no new orders. On 3/29/17, the medication aide replaced the bed alarm on Resident #7□s bed. On 4/7/17, the nurse replaced the bed alarm, again. On 4/12/17, the MDS nurse updated Resident #7□s care plan to include and clarify the expectation that a personal alarm-bed alarm will be provided because Resident #7 slides out of bed often to mat on floor beside bed. On 4/14/17, the interdisciplinary care team, including the hospice nurse and social worker, met with Resident #7□s responsible party to discuss Resident #7□s plan of care, including falls, fall interventions, new chair, and mattress choices. The care plan team and Resident #7□s responsible party agreed: 1) use of new Broda chair, 2) continue with air mattress, and 3) continue with fall mat and bed alarm to help prevent injury when resident slides himself onto floor. What measures were put in place for residents having the potential to be affected By 4/22/17, the DON, ADON, treatment nurse, staff nurse, social worker, activity	

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F 323	Continued From page 27 Intensive Care Unit (ICU) for sepsis from pneumonia. The Emergency Department evaluation dated 03/26/17 specified Resident #2 sustained a right eye contusion and subconjuctival hemorrhage. On 03/29/17 at 12:21 PM nurse aide (NA) #3 was interviewed on the telephone and explained he worked on 03/26/17 from 3 PM to 11 PM and was assigned Resident #2 starting at 7 PM. The NA added that he had been told that same day by another nurse aide that Resident #2 had been making several attempts to get out of bed. NA #3 reported that Resident #2 was at risk for falls and had a sensor alarm in her bed and chair, along with a fall mat and her bed was to be in low position. Adding, Resident #2 was unable to communicate her needs because she could not talk but would wink if she needed something. NA #3 explained that on 03/26/17 on the 3 PM to 11 PM shift the facility only had 3 nurse aides on the "medical unit" because of a shortage and usually the medical unit had 4 nurse aides. He added that during the evening meal, NA #5 was in the dining room assisting residents which left him and NA #4 to monitor "about 30" residents, answer call lights, pass meal trays and feed dependent residents. The NA stated that he entered Resident #2's room to deliver a meal tray when he found the resident on the floor bleeding. He stated the alarm was not sounding. He called for help. NA #3 reported that he examined Resident #2's bed and noticed the alarm was not in place because it was still in her wheelchair. NA #3 added that he was unaware how long Resident #2 had been in the floor. NA #3 stated that he and NA #4 were unable to adequately supervise the residents on the floor and pass meal trays because of the short staffing.	F 323	director, staff facilitator, weekend supervisor, the weekend manager on duty, and/or corporate consultant completed a 100% audit of all resident care guides, comparing the care guide to the resident/resident room/resident chair/resident bed to ensure that: 1) the resident environment remains as free from accident hazards as is possible; and 2) safety interventions are in place and functioning properly, to include checking to make sure bed alarms are on and working. Any environment safety hazards present and/or interventions not in place were immediately corrected by the auditor. By 4/22/17, the administrator directed the use of the quality improvement (QI) administrative round tool on a daily basis as an audit tool to monitor and ensure that: 1) the resident environment remains as free from accident hazards as is possible; and 2) safety interventions are in place and functioning properly, to include check to make sure bed alarms are on and working. Any environment safety hazards present and/or interventions not in place were immediately corrected by the auditor. What systems were put in place to prevent the deficient practice from reoccurring: On 4/18/17, the DON initiated an in-service for all staff on Resident Safety. The in-service addressed safety measures including: call bell within reach,	

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F 323	Continued From page 28 On 03/29/17 at 12:40 PM NA #4 was interviewed on the telephone and stated she was assigned to Resident #2 on 03/26/17 from 3 PM to 7 PM. She explained that during the shift she had to reposition the resident several times back in the bed because she was leaning to one side. The NA added that she was told in report that Resident #2 had a "rough day" and to encourage resident to stay in bed and rest. NA #4 reported that usually Resident #2 was up and ate in the dining room but on 03/26/17 stayed in bed for the evening meal. NA #4 also stated that around 5:30 PM she assisted the resident back in the bed, made sure the bed was in the lowest position and fall mat next to the bed. NA #4 stated that Resident #2 was to have a sensor alarm while in the bed but because the resident was already in bed when the shift started, she didn't check that the alarm was in place and/or functioning. NA #4 explained that she and NA #3 were the only nurse aides on the floor to pass trays and that Nurse #1 was in the dining room helping to feed residents because of short staffing. NA #4 added that around 7 pm she heard NA #3 call for help and was told Resident #2 had fallen. NA #4 stated that she was busy passing trays and had not been able to go back in the room to check on Resident #2 but had assumed she was sleeping because she seemed "out of it." On 03/30/17 at 11:35 AM the Director of Nursing (DON) was interviewed and explained that fall precautions were expected to be in place and it was the responsibility of staff to put them in place. The DON was unaware of the staffing challenges on 03/26/17 on the 3 PM to 11 PM shift and stated there should have been 4 nurse aides on	F 323	frequently used items within reach, non-skid footwear, assisting residents to the bathroom, provide incontinence care, utilize protective equipment such as personal alarms, keep pathways clear, lock bed and wheelchair wheels, safe transfers, and safe positioning. After 4/22/17, staff will not be allowed to complete their shift until this Resident Safety in-service is completed. This in-service will be incorporated into new employee orientation. On 4/4/17, the DON verified the posting of the DON, ADON, and administrator phone numbers at the nurse stations so staff may contact the DON, ADON, and/or administrator when the need arises to protect a resident□s safety. By 4/22/17, the administrator directed the continued use of the quality improvement (QI) administrative round tool on a daily basis as an audit tool to monitor and ensure that: 1) the resident environment remains as free from accident hazards as is possible; and 2) safety interventions are in place and functioning properly, to include bed alarms are on and are working. Any environment safety hazards present and/or interventions not in place were immediately corrected by the auditor. How the facility will monitor systems put in place: On 4/22/17, the administrator, DON, ADON, treatment nurse, staff nurse,	

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F 323	Continued From page 29 the medical unit. The DON stated that she was unaware Resident #2's sensor alarm was not in the bed at the time of the fall and should have been. On 03/30/17 at 12:00 PM observations were made of Resident #2's room that revealed a wheelchair folded beside the closet. Attached to the wheelchair was a sensor alarm. Inside the closet, Resident #2 had a "care guide" (not dated) that instructed staff to monitor the resident's whereabouts and an alarm while in bed. On 03/30/17 at 2:36 PM Nurse #1 was interviewed on the telephone and explained that she was assigned to work 7 AM to 3 PM but no one showed up to relieve her and she agreed to work until 7 PM on 03/26/17. She added that the day was very chaotic due to short staffing and during the 7 AM to 3 PM shift, Resident #2 had made attempts to get out of bed. Nurse #1 reported that she was in the dining room assisting residents with the evening meal when she was told Resident #2 had fallen. She explained that she assessed the resident and noted an injury to the right eye and the right cheek laceration from 03/24/17 had reopened. Nurse #1 stated she contacted the physician and received orders to send the resident to the Emergency Department. Nurse #1 reported that she was unaware if the resident's sensor alarm was sounding at the time of fall because NA #3 was with the resident and her priority was getting Resident #2 sent out to evaluate her injuries. 2. Resident #7 was admitted to the facility on 02/05/16. His diagnoses included dementia with behaviors, diabetes, congestive heart failure, and having repeated falls.	F 323	social worker, activity director, staff facilitator, weekend supervisor, the weekend manager on duty, and/or corporate consultant began auditing resident rooms, hallways, activity rooms, and dining rooms to ensure that: 1) the resident environment remains as free from accident hazards as is possible; and 2) each resident receives adequate supervision and assistance devices to prevent accidents. The audits are recorded on the Showers/CHOICES/ADLs audit tool. If the auditor identifies a resident is not safe or safety devices are not in place, the auditor will take prompt corrective action and document the intervention on the audit tool. The Showers/CHOICES/ADLs audit tool will be completed for five (5) residents daily five (5) times per week for four (4) weeks, then five (5) residents weekly for four (4) weeks, then five (5) residents monthly for two (2) months. Completed Showers/CHOICES/ADLs audit tool tools will be forwarded to and reviewed by the DON and/or ADON. The DON or ADON will present the findings of the Showers/CHOICES/ADLs audit tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as needed or appropriate for continued compliance in this area. Also, the DON and/or ADON will present findings at the quarterly Executive QI	

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F 323	Continued From page 30 A current care plan was developed for his risk of falls which originated on 02/17/16. The goal was for Resident #7 to not sustain any serious injury through the next review of 11/30/16. Interventions included his bed was to be in the lowest position, a fall mat was to be on the floor, and wedges were to be on each side of the bed to determine bed parameters. Under the section of Resident Care Guide initiated 02/16/16 interventions included an alarm in the bed and chair initiated on 02/27/16. The significant change Minimum Data Set (MDS) dated 11/02/16 coded him with long and short term memory impairments and having severely impaired decision making abilities. He was coded as requiring extensive to total assistance with all activities of daily living skills (ADLs). In addition, Resident #7 was coded as having impaired balance, needing assistance to steady himself during transitions and having had 2 or more falls since the previous assessment. The quarterly MDS, dated 02/02/17, coded his cognition as not being assessed, requiring extensive to total assistance with ADLs, being nonambulatory, needing assistance to steady himself during transitions and having had 2 or more falls since the previous admission. A nurse aide care guide was located in Resident 7's the closet which directed nurse aides of individual needs for the resident. This care guide, dated 03/08/17, indicated alarms were to be in both the bed and the chair. Review of the medical record revealed nursing notes dated 03/28/17 at 11:25 AM which stated	F 323	Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	

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F 323	Continued From page 31	F 323		

Resident #7 was found on the floor beside the bed. He was assessed as having no injury. The nursing note did not specify if the alarm was sounding.

Review of the incident report dated 03/29/17 at 12:34 AM stated Resident #7 was observed on the floor beside the bed and received no injuries There was no indication if the alarm was in place or sounding. This was completed by the Assistant Director of Nursing (ADON).

Observations dated 03/29/17 at 10:11 AM, Resident #7 was observed in a low bed with a mat on floor beside the bed. An alarm box was on the bedside table and blinking which indicated it was on. This box was not connected to anything. The resident was lying on a pressure alarm pad and the wire which led from the pad was traced to the floor under the bed. The wire was sheared and not connected to any type of plug as the end was frayed off. The alarm remained not connected during observations of Resident #7 in bed on 03/29/17 at 10:48 AM and at 11:03 AM. On 03/29/17 at 11:25 AM, Nurse Aide #1 entered the room, woke him from sleeping in bed, combed his hair, asked if he was ready to eat lunch and left the room without checking the alarm which remained not connected or functioning.

On 03/29/17 at 11:46 AM, Resident #7 was observed in bed and the cord to the alarm was still not connected and was frayed at the end.

On 03/29/17 at 11:58 AM, Medication Aide #1 was in the room and stated she had just entered and noticed the alarm was not connected. She stated she was not informed about the bed alarm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 323	Continued From page 32 but would replace it. Interview with NA #1 who was responsible for Resident #7's care on 03/29/17, was interviewed on 03/29/17 at 12:03 PM and stated that she did not think she checked the alarm this date. She further stated she provided him incontinent care while in bed this morning and rolled him from side to side and the alarm did not sound. She stated the resident was on a wide pressure alarm pad and believed that was why the alarm did not sound as she rolled him. During interview with the Director of Nursing (DON) on 03/30/17 at 12:00 PM, DON stated she expected Resident #7 to have a working bed alarm in place. She further stated that during care, she expected nursing assistants to review the care guide in the closet and make sure it was followed including checking for alarms in place and in functioning order. The Administrator stated during interview on 03/30/17 at 4:39 PM that alarms should be checked and in working order at each shift change.	F 323		
F 353 SS=G	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 353		4/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 33 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 353	F 353 Staffing	

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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F 353	Continued From page 34 record review the facility failed to have sufficient quantity of staff to monitor a resident at risk for falls; the resident fell and was injured for 1 of 4 sampled residents (Resident #2); and the facility failed to have sufficient quantity of staff to ensure dependent residents were fed and provided incontinence care for 4 of 7 sampled residents (Resident #4, #5, #6 and #7). The facility also failed to have sufficient quantity of staff to have a Registered Nurse function fulltime as a Director of Nursing. The findings included: 1. Cross refer to F 323: Based on observations, staff interviews and record review the facility failed to provide adequate supervision for a resident with a history of falls and ensure fall precautions were in place. The resident fell out of bed and was injured. The resident was sent to the Emergency Department diagnosed with right eye contusion and subconjuctival hemorrhage for 2 of 4 sampled residents (Resident #2 and #7). On 03/30/17 at 10:35 AM the staffing coordinator was interviewed and stated that staffing was hard to maintain and that she used a list to call and "beg" nurses and nurse aides to fill in vacancies in the weekly schedule. She added that she was aware of instances when the vacancies had not been filled and staff had to work short. The staffing coordinator reported that the Administrator was aware of the staffing shortage. On 03/30/17 at 4:45 PM the Administrator was interviewed and stated she was aware the facility was under staffed. The Administrator explained	F 353	What measures did the facility put in place for the resident affected: On 3/24/17, the assigned staff nurse assessed Resident #2 post-fall, contacted the physician, and received physician orders to send Resident #2 to the emergency department for further evaluation. The assigned staff nurse also contacted Resident #2□s responsible party. On 3/26/17, the assigned staff nurse assessed Resident #2 post-fall, contacted the physician, and received physician orders to send Resident #2 to the emergency department for further evaluation. The assigned staff nurse also contacted Resident #2□s responsible party. On 3/30/17, the administrator and the Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care to all residents to include assisting residents with activities of daily living (ADLs) such as shaving and showers. On 3/30/17, the administrator, DON, assistant director of nursing, activity director, social worker, and corporate facility consultant monitored the dining room and resident rooms to ensure dependent residents were assisted with eating and provided incontinence care, including Residents #4, #5, #6, and #7.	

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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F 353	Continued From page 35 that she was working to try to hire staff but faced with a serious challenge. The Administrator reported that she had been working with the facility's corporation to ways to encourage more employment. On 03/30/17 at 5:34 PM the Vice President of Operations was interviewed and stated he was aware of the staffing challenge within the facility. He added that he had implemented bonus pay for staff willing to cover extra shifts and other strategies for filling the vacancies each week. The Vice President of Operations reported that the facility might have to enlist the help of an agency staffing company. 2. Cross refer to F 224: Based on staff interviews and record review the facility neglected to feed and provide incontinence care for dependent residents for 4 of 7 sampled residents (Resident #4, #5 #6 and #7). On 03/30/17 at 10:35 AM the staffing coordinator was interviewed and stated that staffing was hard to maintain and that she used a list to call and "beg" nurses and nurse aides to fill in vacancies in the weekly schedule. She added that she was aware of instances when the vacancies had not been filled and staff had to work short. The staffing coordinator reported that the Administrator was aware of the staffing shortage. On 03/30/17 at 4:45 PM the Administrator was interviewed and stated she was aware the facility was under staffed. The Administrator explained that she was working to try to hire staff but faced with a serious challenge. The Administrator reported that she had been working with the	F 353	What measures were put in place for residents having the potential to be affected: On 3/30/17, the administrator and the DON reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care to all residents to include assisting residents with activities of daily living (ADLs) such as shaving and showers. On 3/30/17, the administrator, DON, assistant director of nursing (ADON), activity director, social worker, and corporate facility consultant monitored the dining room and resident rooms to ensure dependent residents were assisted with eating and provided incontinence care. Starting 4/22/17, a staff member or members will be assigned to assist residents with ADLs daily as ordered and/or outlined in the resident care plan, including assistance with meals, incontinence care, shaving, and showers. By 4/22/17, the administrator notified the Regional Vice President (RVP) of current facility staffing needs to provide nursing care to all residents in accordance with resident care plans. What systems were put in place to prevent the deficient practice from reoccurring: On 3/27/17, the DON initiated an in-service for all registered nurses (RNs),	

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 353	Continued From page 36 facility's corporation to ways to encourage more employment. On 03/30/17 at 5:34 PM the Vice President of Operations was interviewed and stated he was aware of the staffing challenge within the facility. He added that he had implemented bonus pay for staff willing to cover extra shifts and other strategies for filling the vacancies each week. The Vice President of Operations reported that the facility might have to enlist the help of an agency staffing company. 3. Cross refer to F 354: Based on observations, staff interviews and record review the facility failed to have a fulltime Registered Nurse function as a fulltime Director of Nursing. On 03/30/17 at 10:35 AM the staffing coordinator was interviewed and stated that staffing was hard to maintain and that she used a list to call and "beg" nurses and nurse aides to fill in vacancies in the weekly schedule. She added that she was aware of instances when the vacancies had not been filled and staff had to work short. The staffing coordinator reported that the Administrator was aware of the staffing shortage. On 03/30/17 at 4:45 PM the Administrator was interviewed and stated she was aware the facility was under staffed. The Administrator explained that she was working to try to hire staff but faced with a serious challenge. The Administrator reported that she had been working with the facility's corporation to ways to encourage more employment.	F 353	licensed practical nurses (LPNs), nursing assistants (NAs), and geriatric assistants (GAs) related to assisting residents with ADLs (meals, showers, shaving, positioning, etc.). After 4/22/17, no RN, LPN, NA, or GA will be allowed to work until this in-service is completed. All new hires will receive in-services during new employee orientation. On 3/30/17, the vice president of operations implemented bonus pay for staff willing to cover extra shifts. Before 4/22/17, the vice president of operations directed the facility have an afternoon meeting, in addition to the morning meeting, during the week to review daily operations, including mealtime serving/eating assistance, resident concerns, staffing initiatives (applications, interviews, hires) and staffing coverage. Before 4/22/17, the DON and administrator began meeting with staff to set the expectations for: 1) the scheduler to communicate at the daily meetings what the scheduling needs are for the upcoming day, 2) for the scheduler to verify with staff any schedule changes, 3) the scheduler to provide on Friday a copy on of the weekend schedule to the administrator and director of nursing, 4) for the staff to call out to the director of nursing, administrator, weekend supervisor, or manager on duty; it is not acceptable for staff to call and leave a call out message with other staff, 5) the	

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F 353	Continued From page 37 On 03/30/17 at 5:34 PM the Vice President of Operations was interviewed and stated he was aware of the staffing challenge within the facility. He added that he had implemented bonus pay for staff willing to cover extra shifts and other strategies for filling the vacancies each week. The Vice President of Operations reported that the facility might have to enlist the help of an agency staffing company.	F 353	weekend nurse supervisor and manager on duty have access to the staffing agencies to request additional staff, if needed to cover call outs. On 4/22/17, the director of nursing again verified the posting of the DON, ADON, and administrator phone numbers at the nurse stations so staff may contact the DON, ADON, and/or administrator when the need arises to report staffing concerns. By 4/22/17, the administrator and vice president of operations had secured three staffing agencies to provide nursing assistants and nurses on an as needed basis until additional facility staff can be hired and trained. Before 4/22/17, the administrator and vice president of operations coordinated the on-site assistance of corporate nursing consultants, MDS consultants, medical records consultant, dietary consultant, and human resources to aid the facility in recruiting, interviewing, hiring, and/or training new facility staff. Since 3/30/17, new staff have been hired for multiple departments, including nurses and nursing assistants. New staff orientation is ongoing. By 4/22/17, the administrator in-serviced the DON, quality improvement nurse, staff facilitator, and floor nurses that a staff member or members must be assigned on the daily assignment sheet to ensure each resident has staff to assist the	

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 38	F 353		

resident with ADLs. No administrative nurse or floor nurse will be allowed to work until this in-service is completed. All new administrative nurses and floor nurses will receive this in-service during new employee orientation.

How the facility will monitor systems put in place:

On 4/22/17, the Administrator initiated the Sufficient Staff audit tool to monitor for sufficient staffing will be scheduled to provide residents with ADL assistance that enable them to reach their highest practicable physical, mental, psychosocial well-being, including mealtime assistance, shaving, showers, and positioning. The administrator and/or the DON will utilize the Sufficient Staff tool five times weekly to include nights and weekends for four weeks, twice weekly for four weeks, weekly for four weeks, and monthly times three months. Any identified issues will be addressed immediately.

The administrator and/or the DON will present findings from the Sufficient Staff tool at the monthly QI committee meetings for six months for further recommendations.

Beginning 4/22/17, the administrator will monitor the Sufficient Staff tool to ensure proper completion of the Sufficient Staff tool. The administrator will initial the form with the date as completed to acknowledge completion and follow-up.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 353	Continued From page 39	F 353	The administrator will submit the findings at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as needed or appropriate for continued compliance in this area. Also, the administrator will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	
F 354 SS=F	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to have a fulltime Registered Nurse function as a fulltime Director	F 354	F 354 Waiver RN □ 8 hrs 7 Days/Wk, Full Time DON	4/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 354	Continued From page 40 of Nursing. The findings included: On 03/29/17 at 10:15 AM the Director of Nursing (DON) was observed passing medications to residents. On 03/30/17 at 11:00 AM the State Agency asked to interview the Director of Nursing and was told she working a medication cart and would be available for an interview later. On 03/30/17 at 2:25 PM the DON was observed working on a medication cart. On 03/30/17 at 4:15 PM the DON was interviewed and stated 03/06/16 was her first day on the job. The DON explained that staffing was a challenge and in effort to help cover vacancies, the Administrative nurses, including herself, took turns working as a hall nurse. The DON stated that she was aware of the Federal requirements that a DON could not have dual roles. The DON reported that she had been unable to attend a morning management meeting as result of working the medication cart. She reviewed her schedule and worked as a hall nurse on: - 03/17/17 from 7 am to 7 pm - 03/18/17 day off - 03/19/17 day off - 03/20/17 7 am to 3 pm - 03/21/17 7 am to 3 pm - 03/22/17 day off - 03/23/17 8 hours on the cart - 03/24/17 12 hours on the cart - 03/25/17 7 am to 3 pm	F 354	What measures did the facility put in place for the resident affected: On 4/17/17, the administrator began aggressively recruiting, interviewing, and hiring additional nurses, nursing assistants, and geriatric assistants for the nursing department. The newly hired staff will work to assist residents with care and medications thus allowing the director of nursing (DON) to perform the duties of the director of nursing on a fulltime basis. What measures were put in place for residents having the potential to be affected On 4/17/17, the administrator began aggressively recruiting, interviewing, and hiring additional nurses, nursing assistants, and geriatric assistants for the nursing department. The newly hired staff will work to assist residents with care and medications thus having a fulltime registered nurse function as a full time director of nursing. What systems were put in place to prevent the deficient practice from reoccurring: By 4/22/17, the administrator in-serviced the administrative nurses (director of nursing, assistant director of nursing/quality improvement nurse, staff facilitator, treatment nurse) and nursing staff scheduler that a staff member or members must be assigned on the daily assignment sheet to ensure each resident	

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 354	Continued From page 41 On 03/30/17 at 4:45 PM the Administrator was interviewed and stated she was aware of the Federal regulation that required a Registered Nurse to function as fulltime Director of Nursing. She added that due to the staffing challenges of the facility the current Director of Nursing was working as a hall nurse at times. The Administrator stated she believed that resident care came first and made the decision to put residents first.	F 354	has staff to assist the resident with care and medication thus allowing the director of nursing to function as a full time director of nursing. After 4/22/17, no administrative nurse or the scheduler will be allowed to work until this in-service is completed. All new administrative nurses and schedulers will receive this in-service during new employee orientation. How the facility will monitor systems put in place: By 4/22/17, the administrator initiated the Sufficient Staff Audit tool to monitor for the scheduling of sufficient staffing to provide residents care and medication thus allowing the director of nursing, a registered nurse, to function as a full time director of nursing. The administrator will utilize the Sufficient Staff Audit tool five times (5) weekly for four (4) weeks, twice weekly for four (4) weeks, weekly for four (4) weeks, and monthly times three months. Any identified issues will be addressed immediately by the administrator. The administrator will present findings from the Sufficient Staff Audit tool at the monthly QI committee meetings for six months for further recommendations. Also, the administrator will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or	

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F 354	Continued From page 42	F 354	frequency of the continued QI monitoring.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		4/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 43 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to lock an unattended medication cart for 1 of 2 medication carts. The findings included: On 03/29/17 at 8:00 AM a medication cart was left unattended on the medical unit hallway. The medication cart was unlocked. A housekeeping staff member and residents were in the hallway. The housekeeping staff member located Nurse #2 inside the nurses' station. On 03/29/17 at 8:05 AM Nurse #2 was interviewed about the unlocked medication cart. Nurse #2 locked the medication cart and explained that she was the only nurse on the hall waiting for relief from the Director of Nursing and two residents had fallen; and she must have forgot to lock the medication cart to assess the residents. The Nurse stated the medication cart	F 431	F 431 Drug Records, Label/Store Drugs & Biologicals What measures did the facility put in place for the resident affected: On 3/29/17, upon finding the medication cart unattended and not properly secured on the medical unit hallway, the nurse immediately took action to ensure the cart was properly secured. On 3/29/17, the director of nursing (DON) educated the nurse assigned to the medical unit hallway medication cart. What measures were put in place for residents having the potential to be affected On 3/29/17, upon finding the medical unit hallway medication cart was unlocked, the	

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	345502	A. BUILDING _____ B. WING _____	C 03/30/2017

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F 431	Continued From page 44 had been unlocked for at least 20 minutes. On 03/29/17 at 10:00 AM the Administrator was interviewed and reported that medication carts should be locked when unattended.	F 431	administrator, DON, assistant director of nursing (ADON), and/or corporate consultant complete a 100% audit of all medication carts to ensure the facility was free of carts that were not properly secured or left unattended. What systems were put in place to prevent the deficient practice from reoccurring: On 3/29/17, the DON initiated an in-service for all registered nurses (RNs), licensed practical nurses (LPNs) and medication aides on Resident Safety. As of 4/22/17, staff will not be allowed to complete their shift until this Resident Safety in-service is completed. This in-service will be incorporated into new employee orientation. On 4/4/17, the DON verified the posting of the DON, ADON, and administrator phone numbers at the nurse stations so staff may contact the DON, ADON, and/or administrator when the need arises to protect a resident□s safety. How the facility will monitor systems put in place: By 4/22/17, the DON initiated the use of the Medication Cart Audit tool, which includes monitoring for properly secured medication carts and proper drug storage. The administrator, DON, ADON, treatment nurse, staff nurse, social worker, activity director, staff facilitator, weekend supervisor, the weekend	

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F 431	Continued From page 45	F 431	manager on duty, and/or corporate consultant will complete the Medication Cart Audit tool. The Medication Cart Audit tool will be completed for all medication carts daily five (5) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for two (2) months. Completed Cart Audit tools will be forwarded to and reviewed by the DON and/or ADON. The DON or ADON will present the findings of the Medication Cart Audit at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as needed or appropriate for continued compliance in this area. Also, the DON and/or ADON will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	
F 490 SS=G	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 490		4/22/17

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F 490	Continued From page 46 by: Based on observations, staff interviews and record review the facility's Administration failed to manage the care and needs of residents in the building for Resident #s 4, 5, 6, 7, 9 and 2. The findings included: 1. Cross refer to F 224: Based on staff interviews and record review the facility neglected to feed and provide incontinence care for dependent residents for 4 of 7 sampled residents (Resident #4, #5 #6 and #7). On 03/30/17 at 4:45 PM the Administrator was interviewed and stated she was unaware that residents were not fed on 03/26/17 during the evening meal. The Administrator explained additional resources available for staff to use if they ever needed help feeding residents. She stated, the facility had access to her telephone number and that she lived 5 minutes away and would have come in to help feed. The Administrator also stated the facility had department heads that served as "Manager on Duty" and that person could have been called, the facility also had a corporate oversight and access to a corporate consultant for help. The Administrator reported that she should have been contacted on the evening of 03/26/17 so that arrangements could be made to feed residents. 2. Cross refer to F 241: Based on record review, staff interview and family interview, the facility failed to maintain the dignity of 1 of 2 residents sampled for dignity when staff failed to change Resident #7 timely when family	F 490	F 490 Effective Administration What measures did the facility put in place for the resident affected: On 3/29/17, the director of nursing (DON) and/or assistant director of nursing (ADON) assessed Residents #4, #5, #6, and #7. Resident assessment revealed no obvious signs of poor nutrition, change in mental status, or weight loss as a result of not receiving assistance with eating the 3/26/17 evening meal. On 3/29/17, the DON/ADON notified the physician for Residents #4, #5, #6, and #7 and the physician gave no new orders. On 3/18/17, at 2:00 PM the nursing assistant (NA) returned to assist Resident #7 with incontinence care. On 3/29/17, the director of nursing (DON) assessed Resident #7. Resident #7□s skin clean and intact and the brief was dry. On 3/30/17, two nursing assistants assisted Resident #9 with personal care and repositioning. On 3/26/17, the assigned staff nurse assessed Resident #2 post-fall, contacted the physician, and received physician orders to send Resident #2 to the emergency department for further evaluation. The assigned staff nurse also contacted Resident #2□s responsible party. On 3/30/17, the Administrator and the	

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F 490	Continued From page 47 informed staff he was soiled and needed assistance resulting in him being fed by family soiled. 3. Cross refer to F 312: Based on observations, record reviews and resident and staff interviews, the facility failed to provide incontinence care, showers, bed baths and oral care as needed for 1 of 6 residents (Resident #9) sampled for provide activities of daily living. 4. Cross refer to F 323: Based on observations, staff interviews and record review the facility failed to provide adequate supervision for a resident with a history of falls and ensure fall precautions were in place. The resident fell out of bed and was injured. The resident was sent to the Emergency Department diagnosed with right eye contusion and subconjuctival hemorrhage for 1 of 4 sampled residents (Resident #2). 5. Cross refer to F 353: Based on observations, staff interviews and record review the facility failed to have sufficient quantity of staff to monitor a resident at risk for falls; the resident fell and was injured and the facility failed to have sufficient quantity of staff to ensure dependent residents were fed for 4 of 11 sampled residents (Resident #2, #4, #5, #6). The facility also failed to have sufficient quantity of staff to have a Registered Nurse function fulltime as a Director of Nursing. 6. Cross refer to F 354:	F 490	Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care to all residents to include assisting residents with activities of daily living (ADLs) such as shaving and showers. What measures were put in place for residents having the potential to be affected On 4/3/17, the DON initiated an in-service for all staff on abuse/neglect. After 4/3/17, staff will not be allowed to complete their shift until this abuse/neglect in-service is completed. This in-service will be incorporated into new employee orientation. On 4/4/17, the DON verified the posting of the DON, ADON, and administrator phone numbers at the nurse stations so staff may contact the DON, ADON, and/or administrator when the need arises to prevent and/or report abuse/neglect. On 3/30/17, the social worker and admissions/social worker conducted interviews with alert and oriented residents regarding dignity and respect of individuality, including incontinence care before meals. The interviews resulted with no negative findings. On 4/6/17, the social worker called for a resident council meeting to ensure resident council members had an opportunity to express any dignity and respect of individuality concerns.	

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F 490	Continued From page 48 Based on observations, staff interviews and record review the facility failed to have a fulltime Registered Nurse function as a fulltime Director of Nursing.	F 490	On 4/19/17, the social worker reviewed the past 60 days of Resident Concerns to identify any potential dignity and respect of individuality concerns. No unaddressed dignity and respect of individuality concerns were identified. On 3/31/17, the director of nursing (DON), assistant director of nursing (ADON), and hall nurse audited 100% of residents to ensure residents had received assistance with personal care. Any areas of concern were immediately addressed by the auditors. On 4/22/17, the DON, ADON, treatment nurse, staff nurse, social worker, activity director, staff facilitator, weekend supervisor, the weekend manager on duty, and/or corporate consultant completed a 100% audit of all resident care guides, comparing the care guide to the resident/resident room/resident chair to ensure that: 1) the resident environment remains as free from accident hazards as is possible; and 2) safety interventions are in place and functioning properly. Any environment safety hazards present and/or interventions not in place were immediately corrected by the auditor. What systems were put in place to prevent the deficient practice from reoccurring: By 4/22/17, the administrator began using the Administrator Audit tool. The	

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F 490	Continued From page 49	F 490	Administrator Audit tool is an audit summary tool covering tags F224, F241, F281, F312, F323, F353, F354, F431, F490, and F 514. The purpose of the administrator audit tool is to help the administrator ensure the facility is using resources effectively and efficiently to attain or maintain the well-being of each resident. The administrator will complete the Administrator Audit tool twice weekly for 12 weeks then once weekly for 12 weeks. How the facility will monitor systems put in place: The administrator will present the findings of the Administrator Audit tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for six (6) months with recommendation and follow-up as needed or appropriate for continued compliance in this area. Also, the administrator will present findings for six (6) months at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records.	F 514		4/22/17

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F 514	Continued From page 50 (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to document a resident's fall in the medical record for 1 of 4 sampled residents (Resident #2) The findings included:	F 514	F 514 Resident Records What measures did the facility put in place for the resident affected: On 3/30/17, the director of nursing (DON)	

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F 514	Continued From page 51 Resident #2 was admitted to the facility on 03/30/15 and readmitted on 02/13/16 with diagnoses that included encephalopathy, aphasia, hypertension and history of falls. Review of the medical record revealed a physician's order dated 03/26/17 to send the resident to the Emergency Department for evaluation of a fall. Further review of the medical record revealed there was no entry made that documented a fall on 03/26/17. The facility provided an incident report for Resident #2 dated 03/26/17 at 7:18 p.m. completed by Nurse #1 that read in part, resident was found in floor with right eye trauma and a laceration to cheek. On 03/30/17 at 11:25 AM the Director of Nursing (DON) was interviewed and reported that nurses were expected to document events, such as falls, in the medical record. The DON reviewed the medical record of Resident #2 and reported there was no documentation regarding the fall on 03/26/17 in the medical record. On 03/30/17 at 2:36 PM Nurse #1 was interviewed on the telephone and explained that she thought the documentation she made on the incident report automatically populated into the electronic medical record. Nurse #1 was unaware there was no documentation in the medical record regarding the fall for Resident #2 on 03/26/17.	F 514	reviewed Resident #2□s medical record to ensure the medical record progress notes reflected Resident #2□s fall on 3/26/17. What measures were put in place for residents having the potential to be affected By 4/22/17, the DON, assistant director of nursing (ADON), staff nurse, and/or corporate consultant audited 100% of the last 15 days of resident progress notes and resident incident/accident reports to ensure residents who had a fall have proper documentation in the medical record. Any areas of concern were immediately addressed by the auditors. What systems were put in place to prevent the deficient practice from reoccurring: By 4/22/17, the DON initiated an in-service for all registered nurses (RNs), licensed practical nurses (LPNs), nursing assistants (NAs), relaying the importance of, after a resident incident/accident, documenting in the medical record the assessment which includes interventions taken, first aid provided, and notification of the physician and resident□s responsible party. After 4/22/17, no RN, LPN, or NA will be allowed to work until this in-service is completed. All new hires will receive this in-service during new employee orientation. How the facility will monitor systems put in	

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F 514	Continued From page 52	F 514		

place:

By 4/22/17, the administrator, DON, ADON, treatment nurse, staff nurse, social worker, activity director, staff facilitator, weekend supervisor, the weekend manager on duty, and/or corporate consultant began auditing resident medical record progress notes and incident/accident reports to ensure that resident records are complete/accurate/accessible, to include documenting a resident□s fall in the medical record. The audits are recorded on the RP Notification/Resident Record Review tool. If the auditor identifies a resident medical record is not complete/accurate/ accessible, to include documentation of a resident□s fall, the auditor will take prompt corrective action and document on the audit tool the intervention taken. The RP Notification/Resident Record Review tool will be completed for five (5) residents daily five (5) times per week for four (4) weeks, then five (5) residents weekly for four (4) weeks, then five (5) residents monthly for two (2) months. Completed RP Notification/Resident Record Review tool will be forwarded to and reviewed by the DON and/or ADON.

The DON or ADON will present the findings of the RP Notification/Resident Record Review tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as

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F 514	Continued From page 53	F 514	needed or appropriate for continued compliance in this area. Also, the DON and/or ADON will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	